

**COALITION FOR COMMUNITY HEALTH
CHILDHOOD ASTHMA INITIATIVE**

Status Report from Asthma Coordinator (AC) to referring Clinic/Organization

Report Date: ____/____/____

Report sent to: _____

Clinic/Organization: _____

Phone #: () _____

Fax #: () _____

From: _____

Phone #: (213) 748-7123 ext. 237

Fax #: (213) 748-7173

Date of Initial referral: ____/____/____ Client's name: _____

D.O.B.: ____/____/____ CAI ID # A234-_____ ATS ID # _____ - _____

(For patient at partner clinics only)

Contact to Date:	Services Provided to Date:
<div style="display: flex; flex-direction: column; gap: 5px;"><div><input type="checkbox"/> Telephone</div><div><input type="checkbox"/> Initial Home Visit</div><div><input type="checkbox"/> 2nd Home visit</div><div><input type="checkbox"/> Other: _____</div><div>_____</div></div>	<div style="display: flex; flex-direction: column; gap: 5px;"><div><input type="checkbox"/> Education regarding asthma physiology</div><div><input type="checkbox"/> Education regarding medication/medical devices</div><div><input type="checkbox"/> Education regarding the 5 allergen/triggers</div><div><input type="checkbox"/> Assessments of home for allergens</div><div><input type="checkbox"/> Other: _____</div><div>_____</div></div>

1. Client has a copy of asthma plan at home. ☐Yes ☐No, if the answer is No, skip to question # 4.

2. Client's caregiver understands how to use the asthma plan. ☐Yes ☐No, explain why:

3. If they have asthma plan, are they following it? ☐Yes ☐No

4. Client's caregiver administers asthma medication as prescribed (or as appropriate) ☐Yes ☐No, explain why:

5. Client's caregiver demonstrated knowledge on how to use medication/medical devices correctly ☐Yes ☐No, (if no) explain why:

6. Environmental triggers identified at home and recommendations made:

7. Other issues/concerns identified at home visit related to child's asthma care
